DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-6-5

CONCERNING SMALL EMPLOYER GROUP HEALTH BENEFIT PLANS, THE BASIC AND STANDARD HEALTH BENEFIT PLANS, AND PREVENTIVE SERVICES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of the amendment to this regulation is to adopt recommendations from the Health Benefit Plan Advisory Committee for changes to the basic and standard health benefit plans required to be offered to small employer groups and which are used for the purpose of conversion from group coverage as well as to incorporate other changes necessary for compliance with Colorado law. This regulation specifies the requirements for the basic and standard health benefit plans as well as other requirements for small employer carriers.

Section 3 Applicability

This regulation shall apply to all small employer carriers as defined in § 10-16-102(41), C.R.S., and to all carriers required to provide conversion products pursuant to § 10-16-108, C.R.S.

Section 4 Rules

A. Plans

1. Basic Plan. The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to § 10-16-105(7.2), C.R.S. At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and as conversion coverage pursuant to § 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest

in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to § 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to § 10-16-108, C.R.S.

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider or HMO) (Basic Limited Mandate Health Benefit Plan, Basic HSA Health Benefit Plan or Basic HSA Limited Mandate Health Benefit Plan)] for Colorado".

2. Each small employer carrier shall title and market the standard health benefit plan as follows: "[Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO)] Standard Health Benefit Plan for Colorado".

C. A small employer carrier shall actively market the basic and standard health benefit plans to small employers in this state.

D. In marketing the basic and standard health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans to small employers. Any producer authorized by a small employer carrier to market health benefit plans to small employers in the state shall also be authorized to market the basic and standard health benefit plans.

E. Disclosure Statement.

1. The following disclosure statement, prominently displayed in bold face capital letters no smaller than 14 point font for printed materials or in a clear and conspicuous manner for printed materials, electronic or internet-based communications shall appear on all small employer marketing materials (except the Colorado Health Benefit Plan Description Form pursuant to Colorado Insurance Regulation 4-2-20), the Colorado Small Group Uniform Employee Application form, small employer renewal notices, and on all written refusals to insure or issue a policy that are related to health coverage for a business group of one.

"Colorado insurance law requires all carriers in the small group market to issue any health benefit plan it markets in Colorado to small employers of 2-50 employees, including a basic or standard health benefit plan, upon the request of a small employer to the entire small group, regardless of the health status of any of the individuals in the group. Business groups of one cannot be rejected under a basic or standard health benefit plan during open enrollment periods as specified by law."

2. "Clear and conspicuous" means with respect to a disclosure that the disclosure is reasonably understandable and designed to call attention to the nature and significance of the information it contains. A disclosure is considered designed to call attention to the nature and significance of the information in it if the carrier:

a. Uses a typeface and type size that are easy to read;

b. Provides wide margins and ample line spacing;

c. Uses boldface, underscoring, capitals or italics for key words and phrases; and

d. In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the disclosure portion of the document and uses a type size that is greater than the type size predominantly used in the rest of the document or uses style and graphic devices, such as shading or sidebars.

3. If a disclosure is provided on a web page, the carrier shall design its disclosure to call attention to the nature and significance of the information in it. For example, the carrier shall use text or visual cues to encourage scrolling down the page, if necessary, to view the entire disclosure. The carrier shall ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the disclosure, and the carrier either:

a. Places the disclosure on a screen that consumers frequently access, such as a page on which transactions are conducted; or

b. Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the disclosure and is labeled appropriately to convey the importance, nature and relevance of the disclosure.

F. Except as specified in § 10-16-105.2(3), C.R.S., a small employer carrier shall offer the basic and standard health benefit plans along with all of its other small group plans to any small employer that applies for or makes an inquiry regarding health coverage from the small employer carrier. The offer may be provided directly to the small employer or delivered through a producer. The offer shall be in writing and shall include information as required by § 10-16-105(5), C.R.S.

G. Quotes.

1. A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within five (5) business days of receiving all information necessary to provide a requested quote. Each price quote shall be calculated using the carrier's filed rate, as defined in Colorado Insurance Regulation 4-6-7.

2. A small employer carrier shall notify a small employer (directly or through an authorized producer) within five (5) business days of receiving a request for a price quote if any additional information is needed. If a small employer carrier provides a price quote prior to receiving all information necessary to calculate any premium adjustments allowed under § 10-16-105(8.5)(a), C.R.S., that quote shall be the filed rate. The quote shall include a statement indicating that the rate is not final, and once all information is received, the rate will be recalculated using rating factors allowable by law, and may vary from the initial price quote.

3. A price quote shall be provided without requiring verification of the eligibility of the small group, including business groups of one. The fact that a price quote has been issued shall not prevent the small employer carrier from verifying the group's eligibility before issuing the coverage.

4. A small employer carrier shall not apply more stringent or detailed requirements related to the price quote or application process for the basic and standard health benefit plans than are applied for other small group health benefit plans offered by the small employer carrier, except as allowed for underwriting business groups of one.

5. Quotes for the basic and standard health benefit plans shall include quotes for each type of basic and standard health benefit plan the carrier markets (e.g., PPO, indemnity, HMO, HSA-qualified).

H. If a small employer carrier denies coverage to a business group of one for any of its health benefit plans on the basis of risk characteristics, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to the confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following:

1. A copy of the Colorado Health Benefit Plan Description Form for each basic and standard health benefit plan offered by the small employer carrier;

2. A price quote, in the manner required by subsection 4.G. of this regulation, for each such plan if the business group of one is in its open enrollment period or a sample price quote reflecting current rates if the business group of one is not in its open enrollment period. In the case of a sample price quote, the small employer carrier shall disclose that the actual rates may be different than the sample rates if there are changes in the small employer carrier's filed rates or application of rating factors; and

3. Information describing how the business group of one can enroll in such plans. The explanation shall be provided directly to the business group of one or through an authorized producer within the time frames provided in paragraphs G.1. and G.2.

I. A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of small employer health benefit plans in this state. The service shall provide information to callers on how to apply for coverage from the carrier. The information may include the names and phone numbers of producers located geographically proximate to the caller or other such information that is reasonably designed to assist the caller to locate an authorized producer or otherwise apply for coverage through the carrier.

J. A small employer carrier may not require, as a condition for the offer or sale of a basic or standard health benefit plan, that the small employer purchase or qualify for any other product, service, or association.

K. A small employer carrier shall conform to the renewability requirements specified in § 10-16-201.5, C.R.S.

L. Small employer carriers shall elicit, at the time of application, information from applicants necessary to determine whether or not small group laws apply pursuant to § 10-16-105.2(1), C.R.S. If a small employer carrier fails to elicit this information, it shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had done so.

M. Annual Report.

1. A small employer carrier shall file annually, in the manner specified by the Commissioner, information related to the health benefit plans issued by the small employer carrier to small employers in this state. This information shall include, but is not limited to:

a. The number of small employers that were issued health benefit plans in the previous calendar year;

b. The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year;

c. The number of individuals issued coverage under small employer plans who were uninsured for at least three (3) months prior to their effective date of coverage;

d. The total number of individuals, separated as to employees and dependents, insured under basic and standard health benefit plans in the previous calendar year; and

e. The total number of individuals, separated as to employees and dependents, insured under all small employer health benefit plans.

2. The information described in paragraph M.1. shall be filed no later than February 15th of each year in the manner specified by the Commissioner.

Section 5 Incorporated Materials

The Immunization Schedules published by Centers for Disease Control and Prevention shall mean the Childhood Schedule, the Adolescent and Teen Schedule, and the Adult Schedule as exists on the effective date of this regulation and does not include later amendments to or editions of the Immunization Schedules. A copy of the Immunization Schedules may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the Immunization Schedules may be requested from the Center for Disease Control and Prevention (www.cdc.gov). A charge for certification or copies may apply.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspension or revocation of licenses or certificates of authority. Among others, the penalties provided for in § 10-3-1108, C.R.S., may be applied.

Section 8 Effective Date

This amended regulation is effective on October 1, 2011.

Section 9 History

Original regulation effective January 1, 1995.
Amended regulation adopted recommended changes from Health Benefit Plan Advisory Committee to be effective January 1, 1996.
Emergency amendment for exclusion of work related illnesses and injuries effective January 1, 1996.
Amended regulation adopting emergency amendment as permanent effective April 1, 1996.
Amended regulation adopting recommended changes from the Health Benefit Plan Advisory Committee effective January 1, 1997.
Amended regulation incorporating changes required by 1997 legislation and recommendations of the Health Benefit Plan Advisory Committee effective January 1, 1998.
Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 1999.
Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 2000.

Amended regulation, correcting errors in the Basic Indemnity Out-of-Pocket Maximum, the Basic PPO In-network Family Coinsurance, and the Standard Indemnity and PPO Maternity benefit. Corrections effective January 1, 2000.
Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 2001.
Amended regulation incorporating recommendations from the Health Benefit Plan Advisory Committee effective January 1, 2002.
Emergency regulation, effective January 1, 2003.
Amended regulation effective February 1, 2003.
Amended regulation effective January 1, 2004.
Emergency Regulation 04-E-4 effective July 1, 2004.
Emergency Regulation 04-E-9 effective September 29, 2004.
Amended regulation effective November 1, 2004.
Amended regulation effective January 1, 2006.
Amended regulation effective January 1, 2008.
Attachment 1 amended effective March 1, 2008.
Emergency Regulation 08-E-12 effective January 1, 2009.
Amended regulation effective February 1, 2009.
Amended regulation effective January 1, 2010.
Amended regulation effective May 1, 2010.
Emergency Regulation 11-E-02 effective November 1, 2010.
Amended regulation effective February 1, 2011.
Amended regulation effective October 1, 2011.

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR

THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2012

1. The basic health benefit plan as defined by the Commissioner pursuant to § 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider organization (PPO), and health maintenance organization (HMO) plan shall include the specific benefits and coverages outlined in one of the attached tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", or "Basic HSA Limited Mandate Health Benefit Plan".

2. The standard health benefit plan for an indemnity, PPO, and HMO plan shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan".

3. All provisions of Title 10, Article 16 of the Colorado Revised Statutes that apply to small employer group plans shall apply to the basic and standard health benefit plans.

   All other provisions of Title 10 which apply to group sickness and accident insurers, nonprofit health and hospital service corporations, and health maintenance organizations, and all rules related to those provisions, as they relate to small employer group plans, shall also apply to the basic and standard health benefit plans.

4. Modifications to the basic and standard health benefit plans (unless specifically stated otherwise in statute) shall apply to any basic or standard health benefit plan, whether group or conversion, when issued or renewed on or after the effective date specified above.

5. All basic and standard health benefit plans shall also comply with the following requirements:

   A. **Balance Billing:** In-network providers are prohibited from balance billing individuals covered under the basic or standard health benefit plan. "Balance billing" refers to the practice whereby a provider bills an individual for the difference between the amount the provider normally charges for a service and the amount the carrier, policy, or contract recognizes as the allowable charge or negotiated price for the services delivered.

      In the case of indemnity plans and out-of-network PPO plan benefits, carriers shall alert those covered under the basic and standard health benefit plans to the fact that their provider is not prohibited from balance billing except as proscribed in § 10-16-704, C.R.S. Consumers should be encouraged to discuss the issue with their provider.

   B. **Benefit Modifications:** The form and level of coverages specified in the tables labeled "Basic Limited Mandate Health Benefit Plan", "Basic HSA Health Benefit Plan", "Basic HSA Limited Mandate Health Benefit Plan" and "Standard Health Benefit Plan" may be expanded to add additional coverage through a rider or endorsement at the option of the policyholder only.

   C. **Cost Containment:** In their basic and standard health benefit plans, carriers shall disclose whether or not, and to what extent, they use or require the use of the following cost containment approaches: utilization review; second surgical opinions; pre-admission authorization and pre-certification; use of non-physician primary care providers; alternative dispute resolution; and managed care. For PPO plans, accumulations for deductibles and out-of-pocket maximums are calculated separately for in-network and out-of-network. Carriers shall disclose deductible and out-of-pocket maximum calculations on the Colorado Health Benefit Plan Description Form as required in Colorado Insurance Regulation 4-2-20.

Use of gatekeepers is encouraged but not required. Carriers shall offer the most managed care version of each indemnity, PPO, and/or HMO health benefit plan they offer in Colorado. A small employer carrier shall offer the same choice of networks for its basic and standard health benefit plans as it offers for all of its other small group health benefit plans (e.g., if a carrier markets to small employers both a PPO plan with a broad network and one with a limited network, it shall provide basic and standard PPO options using each of the networks).

D. **Eligibility:** "Actively at work" and "non-confinement" provisions are prohibited.

E. **Employer Contribution and Participation Requirements:** The employer contribution and participation requirements applied to the basic and standard health benefit plans shall be in compliance with § 10-16-105(7.4), C.R.S.

F. **Enrollment:** To enroll an employee and dependents, the carrier shall require that:

1. Employers:

   a. Submit a written request for coverage;

   b. Provide information necessary to determine eligibility; and

   c. Agree to pay the required premium.

2. Eligible employees, on the Colorado Small Group Uniform Employee Application form made available by the employer:

   a. Submit a written request for coverage for himself/herself and any dependents; and

   b. Provide information necessary to determine eligibility, if it is required.

G. **Family Planning Services:** Family planning services shall be included as a covered benefit under both the basic and standard health benefit plans. At a minimum, family planning services shall include maternity care, prenatal and postnatal care and counseling, treatment and screening as appropriate for sexually transmitted diseases, sterilization, contraceptives, and contraception counseling.*

H. **Out-of-pocket Maximum:** All cost sharing (deductibles, coinsurance, copays), unless specifically noted otherwise, apply toward the annual out-of-pocket maximum. After the out-of-pocket maximum is satisfied, benefits are paid at 100%. PPO out-of-network, out-of-pocket maximum amounts are separate from the in-network, out-of-pocket maximum amounts.

I. **Primary Care Providers:** Carriers may use non-physician providers, such as certified nurse practitioners and physician's assistants, as primary care providers under the basic and standard health benefit plans. However, carriers are not required to include non-physician providers.

J. **Copays:** All coverages that have any type of flat dollar copay are not subject to the deductible except for the Basic Limited Mandate Health Benefit Plan's prescription drug deductible.

K. **Deductibles:** None of the basic and standard health benefit plans that include deductibles provide fourth quarter carryover credit. PPO out-of-network deductibles are separate from in-network deductibles.

L. **Usual, Customary and Reasonable Determinations:** For all basic and standard health benefit plans, each carrier shall use the same method of determining usual, customary

and reasonable charge allowances as it uses for its most frequently sold non-basic, non-standard group health benefit plan in Colorado.

* Infertility treatment and counseling, and abortion services shall be covered by a carrier under the basic and standard health benefit plans if such services are covered by the carrier under its most frequently sold non-basic, non-standard group health benefit plan in Colorado. Benefits, including deductibles and copayments, shall be provided in accordance with the appropriate level of benefits in the basic and standard health benefit plans based on the type and location of the services provided (e.g., office visit, lab, x-ray, etc.).

[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Health Benefit Plan Description Form. However, it does *not* reflect full compliance with that form as the intent is to provide carriers with a description of the plan benefits.]

JANUARY 1, 2012 COLORADO BASIC LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO AND HMO

PART A: TYPE OF COVERAGE

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	BASIC HMO PLAN
1. TYPE OF PLAN	Medical expense policy	Preferred provider organization plan (PPO)	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? [1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.	Varies by carrier.	Varies by HMO.

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK** [2]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
4. ANNUAL DEDUCTIBLE *(Deductibles apply to all benefits except those with flat dollar copays unless otherwise noted.)*			(Deductibles are separate from in-network deductibles)	
a) Individual	$5,000	$4,000	$8,000	$1,500
b) Family	$15,000	$12,000	$24,000	$4,500
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. The prescription drug deductible and all prescription drug copays are excluded.)*		*(Excludes flat dollar copays.)*	*(Out-of pocket amounts are separate from in-network out-of-pocket amounts.)*	
a) Individual	$13,000	$10,000	$16,000	$10,000
b) Family	$26,000	$20,000	$32,000	$20,000
5A. COINSURANCE (amount paid by carrier) **or COPAY** (amount paid by insured/member)	50% coinsurance	70% coinsurance	50% coinsurance	Depends on the service, see details below. [4]
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum.	No lifetime maximum.		No lifetime maximum.
7A. COVERED PROVIDERS	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [2]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO.
8. MEDICAL OFFICE VISITS [5]				
PCP	50% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit
Specialist	50% coinsurance	$60 copay/visit	50% coinsurance	$60 copay/visit
9. PREVENTIVE CARE [6, 6a]	For all plans, only specified preventive services are covered.			
a) Children's services *(No deductible prior to application of coinsurance.)*	50% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit
b) Adult services [6b]	50% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit
c) Colorectal screening services [6c]	100% coverage *(No deductible)*	100% coverage *(No deductible)*	$40 copay for office visits $500 copay for outpatient/ambulatory surgery procedures *(No deductible)*	100% coverage
d) State mandated preventive services [6, 6a, 6b]	100% coverage *(No deductible)*	$40 copay/visit *(No deductible)*		$40 copay/visit *(No deductible)*
10. MATERNITY [7]	50% coinsurance	70% coinsurance (Applicable copays, deductible and coinsurance apply to each type of service.)	50% coinsurance	Applicable copays for each type of service [8]

	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
BASIC LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK** [2]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
11. PRESCRIPTION DRUGS [9] **Deductible** *(Must be satisfied prior to application of copays.)* *(Deductible and copays do not apply to out-of-pocket maximums.)*	$150 annual deductible per person	$150 annual deductible per person		$150 annual deductible per person (Not included in out-of-pocket maximum)
	$20 copay preferred generic $50 copay preferred brand name $70 copay non-preferred [9a]	$20 copay preferred generic $50 copay preferred brand name $70 copay non-preferred [9a]		$20 copay preferred generic $50 copay preferred brand name $70 copay non-preferred [9a]
12. INPATIENT HOSPITAL	50% coinsurance	70% coinsurance	50% coinsurance	$1,000/day to $4,000 max. per admission [10] *(No deductible.)*
13. OUTPATIENT/AMBULATORY SURGERY	50% coinsurance	70% coinsurance	50% coinsurance	$500 copay/visit[10a]
14. DIAGNOSTICS [11]				
a) Laboratory & X-ray	50% coinsurance	70% coinsurance	50% coinsurance	No copay
b) MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
15. EMERGENCY CARE [12, 13]	50% coinsurance	$250 copay then carrier pays 70% coinsurance *(No deductible)*		$250 copay/visit [14] for in- and out-of-network emergency care.
16. AMBULANCE	50% coinsurance	70% coinsurance *After satisfaction of in-network deductible.*		30% copay
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	50% coinsurance	$100 copay	50% coinsurance	$100 copay/visit. *Out-of-network urgent care covered only if temporarily out of service area.*

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [2]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
18. BIOLOGICALLY BASED MENTAL ILLNESS [15] **CARE**	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	Excluded	Excluded		Excluded
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% coinsurance. (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)		Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% copay.
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [16]	50% coinsurance **(Limited to 20 visits per therapy per year)**[16a]	70% coinsurance **(Limited to 20 visits per therapy per year combined in and out-network)** [16a]	50% coinsurance	$40 copay **(Limited to 20 visits per therapy per year)** [16a]
22. DURABLE MEDICAL EQUIPMENT [17]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
23. OXYGEN	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
24. ORGAN TRANSPLANTS [18]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	50% coinsurance	70% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [2]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
25. HOME HEALTH CARE [18a]	50% coinsurance Limited to 60 visits per year	70% coinsurance Limited to 60 visits per year combined maximum	50% coinsurance	30% copay per visit Limited to 60 visits per year
26. HOSPICE CARE [18a, 18b]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
27. SKILLED NURSING FACILITY CARE [19]	50% coinsurance (Not to exceed 100 days/year)	70% coinsurance (Not to exceed 100 days/year)	50% coinsurance	30% copay/day (Not to exceed 100 days/year)
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident. [6a, 21a]			
29. VISION CARE	Excluded [6a]	Excluded [6a]	Excluded [6a]	Excluded [6a]
30. CHIROPRACTIC CARE	Excluded	Excluded	Excluded	Excluded
31. SIGNIFICANT ADDITIONAL SERVICES				
a) Hearing Aids [19a]	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service
b) Treatment of Autism Spectrum Disorders [19b]	Benefit level determined by type of service provided [19c]	Benefit level determined by type of service provided [19c]	Benefit level determined by type of service provided [19c]	Benefit level determined by type of service provided [19c]

PART C: LIMITATIONS AND EXCLUSIONS

BASIC LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [20, 20a, 21]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 – 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS **Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No	No	No	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employer liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[21a]; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids and fitting[21b]; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [22]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

1 Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the carrier may require the insured/member to use in order to get any coverage at all under the plan, or that the carrier may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

2 Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply only if the carrier has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network levels apply.

3 "Out-of-pocket annual maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copays, as specified. The deductible and copays for prescription drugs, however, are not applied to the out-of-pocket maximum. Under this basic plan, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

4 However, notwithstanding the copay amounts listed in the basic HMO plan, under no circumstances, with the exception of the prescription drug benefit, shall the copay amount paid by the insured/member exceed 50% of charges for any single service.

5 Medical office visits include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

6 Effective January 1, 2010, coverage includes all preventive services as set forth in § 10-16-104(18), C.R.S. in accordance with "A" and "B" recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided pursuant to Colorado Insurance Bulletin B-4.24. For the basic HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

6a The covered preventive services, including immunizations and vaccinations, for adults and children are listed in Attachment 1 of this regulation. For those services denoted with Attachment 1's footnote 5:

In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers (for plans with out-of-network benefits): These services can be subject to the plan's out-of-network cost sharing requirements.

6b Prostate cancer screening is not covered. The coverage requirements set forth in § 10-16-104(18), C.R.S., do apply to the Basic Limited Mandate Health Benefit Plans.

6c Coverage shall be provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

7 Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

8 The hospital copay applies to mother and well baby together; there are not separate copays.

9 Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids pursuant to § 10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health benefit plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefit deductibles and copays are not applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (e.g., office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type).

9a Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

10 Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

10a Copay includes all physician, facility services and supplies delivered during the visit.

11 Includes diagnostic low dose mammography not otherwise covered under the list of preventive care services, as set forth in Colorado law, § 10-16-104(18)(b)(III)(C), C.R.S. (Routine mammography screenings are covered.) Diagnostic services do not include therapeutic treatment.

12 "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the carrier for non-emergency after hours care, then urgent care coinsurance and copays apply.

14 Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

15 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits.

16 Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age.

16a The services covered and the benefits provided for children under 6 years of age shall be pursuant to the requirements of § 10-16-104, C.R.S., subsections (1.3) and (1.7). Annual maximum for early intervention services is published in Colorado Insurance Bulletin B-4.31. For children under the age of 19, the services provided for the treatment of autism spectrum disorders pursuant to § 10-16-104(1.4), C.R.S., shall exceed the benefit limits if such therapy is medically necessary.

17 Coverage is for the lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered but repair and replacement needed due to misuse/abuse by the insured/member is not covered.

18 Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure and shall include animal-to-human and artificial and mechanical devices as medically appropriate.

18a Covered services are defined in Colorado Insurance Regulation 4-2-8.

18b Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

19 Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

19a Hearing aids for dependent children under the age of 18 are covered pursuant to § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

19b Effective July 1, 2010, all medically necessary, appropriate, effective or efficient treatments and/or services for the treatment of autism spectrum disorders as set forth in § 10-16-104(1.4), C.R.S., are covered for children under nineteen years of age. The treatments listed in § 10-16-104(1.4)(a)(XII), C.R.S. are not considered to be experimental or investigational and are considered to be appropriate, effective, or efficient for the treatment of autism.

19c The benefits provided are subject to the dollar limits, deductibles, copays, or coinsurance limits for the type and place of service for the treatment being provided unless otherwise noted. However, the benefits provided pursuant to § 10-16-104(1.4), C.R.S., are in addition to any benefits provided pursuant to subsections (1.3) and (1.7) of § 10-16-104, C.R.S. The following annual maximums are effective for applied behavior analysis services:

- From birth up to, but not including age nine: $34,000.
- Age nine up to, but not including age nineteen: $12,000.

20 Waiver of pre-existing condition exclusions: State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage the insured/member recently may have had.

20a Pre-existing condition exclusions shall not be applied to individuals under the age of 19.

21 The carrier shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

21a Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

21b Only hearing aids for dependent children under the age of 18 are covered in pursuant to § 10-16-104(19), C.R.S.

22 Except that if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Health Benefit Plan Description Form. However, it does *not* reflect full compliance with that form as the intent is to provide carriers with a description of the plan benefits.]

JANUARY 1, 2012 COLORADO BASIC HSA HEALTH BENEFIT PLANS:

INDEMNITY, PPO, AND HMO

PART A: TYPE OF COVERAGE

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	BASIC HMO PLAN
1. TYPE OF PLAN	Medical expense policy	Preferred provider organization plan (PPO)	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.	Varies by carrier.	Varies by HMO.

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
BASIC HSA HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
4. ANNUAL DEDUCTIBLE [2]	***For all plans, deductible applies to all services unless specifically noted.***			
a) Single Coverage	$4,000	$4,000	$8,000	$4,000
b) Non-Single Coverage (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children)	$8,000	$8,000	$16,000 *(Deductibles are separate from in-network deductibles.)*	$8,000
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Includes deductibles, coinsurance and copays.)*				
a) Single Coverage	$5,950	$5,950	$11,600	$5,950
b) Non-Single Coverage (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children)	$11,900	$11,900	$23,200 *(Out-of pocket amounts are separate from in-network out-of-pocket amounts.)*	$11,900
5A. COINSURANCE (amount paid by carrier) **or COPAY** (amount paid by the insured/member)	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum.	No lifetime maximum.		No lifetime maximum.
7A. COVERED PROVIDERS	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.

BASIC HSA HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK**[1a]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO.
8. MEDICAL OFFICE VISITS [4] **PCP or Specialist**	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
9. PREVENTIVE CARE [5, 5a]	For all plans, only specified preventive services are covered.			
a) Children's services *(No deductible)*	50% coinsurance	$40 copay/visit.	50% coinsurance	$40 copay/visit.
b) Adult services *(No deductible)*	50% coinsurance	$40 copay/visit.	50% coinsurance	$40 copay/visit.
c) Colorectal screening services [5b]	100% coverage *(No deductible.)*	100% coverage *(No deductible.)*	$40 copay for office visits $500 copay for outpatient ambulatory/surgery procedures *(No deductible.)*	100% coverage
d) State mandated preventive services [5, 5a]	100% coverage *(No deductible)*	$40 copay/visit *(No deductible)*		$40 copay/visit
10. MATERNITY [6] *(Deductible, coinsurance, and copay percentage apply to all services.)*	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
11. PRESCRIPTION DRUGS [7, 8] *(Deductible and out-of-pocket maximums apply.)*	50% coinsurance	50% coinsurance	50% coinsurance	50% copay
12. INPATIENT HOSPITAL [9]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
13. OUTPATIENT/AMBULATORY SURGERY	50% coinsurance	70% coinsurance	50% coinsurance	30% copay

BASIC HSA HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
14. DIAGNOSTICS [10]				
a) Laboratory & X-ray	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
b) MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
15. EMERGENCY CARE [11, 12]	50% coinsurance	70% coinsurance *(In-network deductible applies regardless of where service is provided.)*		30% copay
16. AMBULANCE	50% coinsurance	70% coinsurance *After satisfaction of in-network deductible.*		30% copay
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
18. BIOLOGICALLY BASED MENTAL ILLNESS [13] **CARE**	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. OTHER MENTAL HEALTH CARE [14]				
a) Inpatient care [14a]	50% coinsurance. Maximum 45 inpatient or 90 partial days/year.	50% coinsurance. Maximum 45 inpatient or 90 partial days/year.		50% copay. Maximum 45 inpatient or 90 partial days/year.
b) Outpatient care	50% coinsurance. Plan/Insurer pays a maximum of 20 visits per year.	50% coinsurance. Plan/Insurer pays a maximum of 20 visits per year. (In-network deductible applies to network providers and out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)		50% copay. Plan pays a maximum of 20 visits per year.

BASIC HSA HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK**[1a]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% coinsurance.	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% coinsurance. (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)		Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% copay.
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [15]	50% coinsurance **(Limited to 20 visits per therapy per year)**[15a]	70% coinsurance **(Limited to 20 visits per therapy per year)** [15a]	50% coinsurance	30% copay **(Limited to 20 visits per therapy per year)** [15a]
22. DURABLE MEDICAL EQUIPMENT [16]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
23. OXYGEN	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
24. ORGAN TRANSPLANTS [17]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
25. HOME HEALTH CARE [17a]	50% coinsurance Limited to 60 visits per year	70% coinsurance Limited to 60 visits per year combined maximum	50% coinsurance	30% copay Limited to 60 visits per year
26. HOSPICE CARE [17a, 18]	50% coinsurance per diem	70% coinsurance per diem	50% coinsurance per diem	30% copay per diem

BASIC HSA HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
27. SKILLED NURSING FACILITY CARE [19]	50% coinsurance (Not to exceed 100 days/year)	70% coinsurance (Not to exceed 100 days/year)	50% coinsurance	30% copay (Not to exceed 100 days/year)
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident. [5a, 21a]			
29. VISION CARE	Excluded [5a]	Excluded [5a]	Excluded [5a]	Excluded [5a]
30. CHIROPRACTIC CARE	Excluded	Excluded	Excluded	Excluded
31. SIGNIFICANT ADDITIONAL SERVICES				
a) Hearing Aids [19a]	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service
b) Treatment of Autism Spectrum Disorders [19b]	Benefit level determined by type of service provided[19c]	Benefit level determined by type of service provided[19c]	Benefit level determined by type of service provided[19c]	Benefit level determined by type of service provided [19c]

PART C: LIMITATIONS AND EXCLUSIONS

BASIC HSA HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [20, 20a, 21]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 – 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions.

	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
BASIC HSA HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK**	
33. EXCLUSIONARY RIDERS **Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No	No	No	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[21a]; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids and fitting[21b]; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [22]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

1 Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the carrier may require the insured/member to use in order to get any coverage at all under the plan, or that the carrier may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

1a Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply only if the carrier has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

2 Annual Deductible: The stated annual deductible must be met prior to any benefits being payable except as otherwise indicated.

3 "Out-of-pocket annual maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, copays, and coinsurance.

4 Medical office visits include physician, mid-level practitioner, and specialist visits including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

5 Effective January 1, 2010, coverage includes all preventive services as set forth in § 10-16-104(18), C.R.S. in accordance with "A" and "B" recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided pursuant to Colorado Insurance Bulletin B-4.24. For the basic HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

5a The covered preventive services, including immunizations and vaccinations, for adults and children are listed in Attachment 1 of this regulation. For those services denoted with Attachment 1's footnote 5:

In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers (for plans with out-of-network benefits): These services can be subject to the plan's out-of-network cost sharing requirements.

5b Coverage shall be provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

6 Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

7 Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids pursuant to § 10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health benefit plan in Colorado.

8 Prescription drugs otherwise excluded are not covered.

9 Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

10 Includes diagnostic low dose mammography not otherwise covered under the list of preventive care services, as set forth in Colorado law, § 10-16-104(18)(b)(III)(C), C.R.S. (Routine mammography screenings are covered.) Diagnostic services do not include therapeutic treatment.

11 "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

12 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the carrier for non-emergency after hours care, then urgent care coinsurance applies.

13 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits.

14 Pursuant to § 10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to § 10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of § 10-16-105(2), C.R.S., relating to such an exclusion.

14a The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

15 Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age.

15a The services covered and the benefits provided for children under 6 years of age shall be pursuant to the requirements of § 10-16-104, C.R.S., subsections (1.3) and (1.7). Annual maximum for early intervention services is published in Colorado Insurance Bulletin B-4.31. For children under the age of 19, the services provided for the treatment of autism spectrum disorders pursuant to § 10-16-104(1.4), C.R.S., shall exceed the benefit limits if such therapy is medically necessary.

16 Coverage is for the lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered but repair and replacement needed due to misuse/abuse by the insured/member is not covered.

17 Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure and shall include animal-to-human and artificial and mechanical devices as medically appropriate.

17a Covered services are defined in Colorado Insurance Regulation 4-2-8.

18 Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

19 Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

19a Hearing aids for dependent children under the age of 18 are covered pursuant to § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

19b Effective July 1, 2010, all medically necessary, appropriate, effective or efficient treatments and/or services for the treatment of autism spectrum disorders as set forth in § 10-16-104(1.4), C.R.S., are covered for children under nineteen years of age. The treatments listed in § 10-16-104(1.4)(a)(XII), C.R.S. are not considered to be experimental or investigational and are considered to be appropriate, effective, or efficient for the treatment of autism.

19c The benefits provided are subject to the dollar limits, deductibles, copays, or coinsurance limits for the type and place of service for the treatment being provided unless otherwise noted. However, the benefits provided pursuant to § 10-16-104(1.4), C.R.S., are in addition to any benefits provided pursuant to subsections (1.3) and (1.7) of § 10-16-104, C.R.S. The following annual maximums are effective for applied behavior analysis services:

- From birth up to, but not including age nine: $34,000.
- Age nine up to, but not including age nineteen: $12,000.

20 Waiver of pre-existing condition exclusions: State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage the insured/member recently may have had.

20a Pre-existing condition exclusions shall not be applied to individuals under the age of 19.

21 The carrier shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

21a Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

21b Only hearing aids for dependent children under the age of 18 are covered pursuant to § 10-16-104(19), C.R.S.

22 Except that if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Health Benefit Plan Description Form. However, it does *not* reflect full compliance with that form as the intent is to provide carriers with a description of the plan benefits.]

JANUARY 1, 2012 COLORADO BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLANS:

INDEMNITY, PPO, AND HMO

PART A: TYPE OF COVERAGE

	BASIC INDEMNITY PLAN	BASIC PPO PLAN	BASIC HMO PLAN
1. TYPE OF PLAN	Medical expense policy	Preferred provider organization plan (PPO)	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? [1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.	Varies by carrier.	Varies by HMO.

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
4. ANNUAL DEDUCTIBLE [2]	***For all plans, deductible applies to all services unless specifically noted.***			
a) Single Coverage	$4,000	$4,000	$8,000	$4,000
b) Non-Single Coverage (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children)	$8,000	$8,000	$16,000 *(Deductibles are separate from in-network deductibles)*	$8,000
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Includes deductibles, coinsurance and copays.)*				
a) Single Coverage	$5,950	$5,950	$11,600	$5,950
b) Non-Single Coverage (Employee + Spouse *or* Employee + Children *or* Employee, Spouse and Children)	$11,900	$11,900	$23,200 *(Out-of pocket amounts are separate from in-network out-of-pocket amounts.)*	$11,900
5A. COINSURANCE (amount paid by carrier) **or COPAY** (amount paid by the insured/member)	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum.	No lifetime maximum.		No lifetime maximum.

	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
7A. COVERED PROVIDERS	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO.
8. MEDICAL OFFICE VISITS [4] **PCP or Specialist**	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
9. PREVENTIVE CARE [5, 5a]	For all plans, only specified preventive services are covered.			
a) Children's services *(No deductible)*	50% coinsurance	$40 copay/visit.	50% coinsurance	$40 copay/visit.
b) Adult services [5b] *(No deductible)*	50% coinsurance	$40 copay/visit.	50% coinsurance	$40 copay/visit.
c) Colorectal screening services [5c]	100% coverage *(No deductible.)*	100% coverage *(No deductible.)*	$40 copay for office visits $500 copay for outpatient ambulatory/surgery procedures *(No deductible.)*	100% coverage
d) State mandated preventive services [5, 5a, 5b]	100% coverage *(No deductible.)*	$40 copay/visit *(No deductible.)*		$40 copay/visit *(No deductible.)*
10. MATERNITY [6] *(Deductible, coinsurance, and copay percentage apply to all services.)*	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
11. PRESCRIPTION DRUGS [7, 8] *(Deductible and out-of-pocket maximums apply.)*	50% coinsurance	50% coinsurance	50% coinsurance	50% copay

	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLAN		**IN-NETWORK**	**OUT-OF-NETWORK[1a]**	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
12. INPATIENT HOSPITAL [9]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
13. OUTPATIENT/AMBULATORY SURGERY	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
14. DIAGNOSTICS [10]				
a) Laboratory & X-ray	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
b) MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
15. EMERGENCY CARE [11, 12]	50% coinsurance	70% coinsurance (In-network deductible applies regardless of where service is provided.)		30% copay
16. AMBULANCE	50% coinsurance	70% coinsurance *After satisfaction of in-network deductible.*		30% copay
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
18. BIOLOGICALLY BASED MENTAL ILLNESS [13] CARE	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	Excluded	Excluded	Excluded	Excluded

BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% coinsurance. (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)		Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% copay.
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [14]	50% coinsurance **(Limited to 20 visits per therapy per year)[14a]**	70% coinsurance **(Limited to 20 visits per therapy per year combined in- and out-network) [14a]**	50% coinsurance	30% copay **(Limited to 20 visits per therapy per year) [14a]**
22. DURABLE MEDICAL EQUIPMENT [15]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
23. OXYGEN	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
24. ORGAN TRANSPLANTS [16]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
25. HOME HEALTH CARE [16a]	50% coinsurance Limited to 60 visits per year	70% coinsurance Limited to 60 visits per year combined maximum	50% coinsurance	30% copay Limited to 60 visits per year
26. HOSPICE CARE [16a, 16b]	50% coinsurance per diem	70% coinsurance per diem	50% coinsurance per diem	30% copay per diem
27. SKILLED NURSING FACILITY CARE [17]	50% coinsurance (Not to exceed 100 days/year)	70% coinsurance (Not to exceed 100 days/year)	50% coinsurance	30% copay (Not to exceed 100 days/year)

BASIC HSA LIMITED MANDATE HEALTH BENEFIT PLAN	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident. [5a, 19a]			
29. VISION CARE	Excluded [5a]	Excluded [5a]	Excluded [5a]	Excluded [5a]
30. CHIROPRACTIC CARE	Excluded	Excluded	Excluded	Excluded
31. SIGNIFICANT ADDITIONAL SERVICES				
a) Hearing Aids [17a]	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service
b) Treatment of Autism Spectrum Disorders [17b]	Benefit level determined by type of service provided[17c]	Benefit level determined by type of service provided[17c]	Benefit level determined by type of service provided[17c]	Benefit level determined by type of service provided[17c]

PART C: LIMITATIONS AND EXCLUSIONS

Basic HSA Limited Mandate Health Benefit Plan	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [18, 18a, 19]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 – 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS **Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No	No	No	No

Basic HSA Limited Mandate Health Benefit Plan	BASIC INDEMNITY PLAN	BASIC PPO PLAN		BASIC HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK[1a]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[19a]; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids and fitting[19b]; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [20]; transplants except for those listed above; charges for surgical treatment of obesity; and war.			

1 Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the carrier may require the insured/member to use in order to get any coverage at all under the plan, or that the carrier may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

1a Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply only if the carrier has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

2 Annual Deductible: The stated annual deductible must be met prior to any benefits being payable except as otherwise indicated.

3 "Out-of-pocket annual maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, copays, and coinsurance.

4 Medical office visits include physician, mid-level practitioner, and specialist visits including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

5 Effective January 1, 2010, coverage includes all preventive services as set forth in § 10-16-104(18), C.R.S. in accordance with "A" and "B" recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided pursuant to Colorado Insurance Bulletin B-4.24. For the basic HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

5a The covered preventive services, including immunizations and vaccinations, for adults and children are listed in Attachment 1 of this regulation. For those services denoted with Attachment 1's footnote 5:

In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers (for plans with out-of-network benefits): These services can be subject to the plan's out-of-network cost sharing requirements.

5b Prostate cancer screening is not covered. The coverage requirements set forth in § 10-16-104(18), C.R.S., do apply to the Basic HSA Limited Mandate Health Benefit Plans.

5c Coverage shall be provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

6 Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

7 Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids pursuant to § 10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado.

8 Prescription drugs otherwise excluded are not covered.

9 Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

10 Includes diagnostic low dose mammography not otherwise covered under the list of preventive care services, as set forth in Colorado law, § 10-16-104(18)(b)(III)(C), C.R.S. (Routine mammography screenings are covered.) Diagnostic services do not include therapeutic treatment.

11 "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

12 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the carrier for non-emergency after hours care, then urgent care coinsurance applies.

13 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits.

14 Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age.

14a The services covered and the benefits provided for children under 6 years of age shall be pursuant to the requirements of § 10-16-104, C.R.S., subsections (1.3) and (1.7). Annual maximum for early intervention services is published in Colorado Insurance Bulletin B-4.31. For children under the age of 19, the services provided for the treatment of autism spectrum disorders pursuant to § 10-16-104(1.4), C.R.S., shall exceed the benefit limits if such therapy is medically necessary.

15 Coverage is for the lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered but repair and replacement needed due to misuse/abuse by the insured/member is not covered.

16 Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure and shall include animal-to-human and artificial and mechanical devices as medically appropriate.

16a Covered services are defined in Colorado Insurance Regulation 4-2-8.

16b Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

17 Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

17a Hearing aids for dependent children under the age of 18 are covered pursuant to § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

17b Effective July 1, 2010, all medically necessary, appropriate, effective or efficient treatments and/or services for the treatment of autism spectrum disorders as set forth in § 10-16-104(1.4), C.R.S., are covered for children under nineteen years of age. The treatments listed in § 10-16-104(1.4)(a)(XII), C.R.S. are not considered to be experimental or investigational and are considered to be appropriate, effective, or efficient for the treatment of autism.

17c The benefits provided are subject to the dollar limits, deductibles, copays, or coinsurance limits for the type and place of service for the treatment being provided unless otherwise noted. However, the benefits provided pursuant to §10-16-104(1.4), C.R.S., are in addition to any benefits provided pursuant to subsections (1.3) and (1.7) of § 10-16-104, C.R.S. The following annual maximums are effective for applied behavior analysis services:

- From birth up to, but not including age nine: $34,000.
- Age nine up to, but not including age nineteen: $12,000.

18 Waiver of pre-existing condition exclusions: State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage insured/member recently may have had.

18a Pre-existing condition exclusions shall not be applied to individuals under the age of 19.

19 The carrier shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

19a Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

19b Only hearing aids for dependent children under the age of 18 are covered pursuant to § 10-16-104(19), C.R.S.

20 Except that if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

[NOTE: This benefit grid has been formatted to more closely conform to the Colorado Health Benefit Plan Description Form. However, it does *not* reflect full compliance with that form as the intent is to provide carriers with a description of the plan benefits.]

JANUARY 1, 2012 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PPO, AND HMO

PART A: TYPE OF COVERAGE

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN	STANDARD HMO PLAN
1. TYPE OF PLAN	Medical expense policy	Preferred provider organization plan (PPO)	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? [1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.	Varies by carrier.	Varies by HMO.

PART B: SUMMARY OF BENEFITS

(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the flat dollar or percentage copay listed is what the member will pay.)

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
4. ANNUAL DEDUCTIBLE *(Deductibles apply to all benefits except those with flat dollar copays unless otherwise noted.)*			*(Deductibles are separate from in-network deductibles)*	
a) Individual	$2,000	$1,500	$3,000	$500
b) Family	$6,000	$4,500	$9,000	$1,500
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Includes deductibles and coinsurance. Copays apply for the HMO plan only. All copays for prescription drugs are excluded.)*		*(Excludes flat dollar copays.)*	*(Out-of-pocket amounts are separate from in-network out-of-pocket amounts.)*	
a) Individual	$5,000	$4,500	$9,000	$4,500
b) Family	$15,000	$9,000	$18,000	$9,000
5A. COINSURANCE (amount paid by carrier) **or COPAY** (amount paid by insured/member)	80% coinsurance	80% coinsurance	50% coinsurance	Depends on the service, see details below. [4]
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum.	No lifetime maximum.		No lifetime maximum.

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
7A. COVERED PROVIDERS	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO.
8. MEDICAL OFFICE VISITS [5]				
PCP	80% coinsurance	$30 copay/visit	50% coinsurance	$30 copay/visit
Specialist	80% coinsurance	$50 copay/visit	50% coinsurance	$50 copay/visit
9. PREVENTIVE CARE [6, 6a]	For all plans, only specified preventive services are covered.			
a) Children's services *(No deductible prior to application of coinsurance.)*	80% coinsurance	$30 copay/visit	50% coinsurance	$30 copay/visit
b) Adult services	80% coinsurance	$30 copay/visit	50% coinsurance	$30 copay/visit
c) Colorectal screening services [6b]	100% coverage *(No deductible.)*	100% coverage *(No deductible.)*	$30 copay for office visits $250 copay for outpatient ambulatory/surgery procedures *(No deductible.)*	100% coverage
d) State mandated preventive services [6, 6a]	100% coverage *(No deductible)*	$30 copay/visit *(No deductible)*		$30 copay/visit *(No deductible)*
10. MATERNITY [7]	80% coinsurance Deductible and coinsurance apply	80% coinsurance (Applicable copays, deductible and coinsurance apply to each type of service.)	50% coinsurance	Applicable copays for each type of service [8]

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
11. PRESCRIPTION DRUGS [9] *(Copays do not apply to out-of-pocket maximums.)*	$15 copay preferred generic $40 copay preferred brand name $60 copay non-preferred [9a]	$15 copay preferred generic $40 copay preferred brand name $60 copay non-preferred [9a]	$15 copay preferred generic $40 copay preferred brand name $60 copay non-preferred [9a]	$15 copay preferred generic $40 copay preferred brand name $60 copay non-preferred [9a]
12. INPATIENT HOSPITAL	80% coinsurance	80% coinsurance	50% coinsurance	$500/day to a max. of $2,000 per admission [10]
13. OUTPATIENT/AMBULATORY SURGERY	80% coinsurance	80% coinsurance	50% coinsurance	$250 copay/visit [10a]
14. DIAGNOSTICS [11]				
a) Laboratory & X-ray	80% coinsurance	80% coinsurance	50% coinsurance	100% coverage
b) MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans	80% coinsurance	80% coinsurance	50% coinsurance	20% copay
15. EMERGENCY CARE [12, 13]	80% coinsurance	$150 copay then plan pays 80% coinsurance *(No deductible.)*		$150 copay/visit [14] for in- and out-of-network emergency care.
16. AMBULANCE	80% coinsurance	80% coinsurance *(After satisfaction of in-network deductible.)*		20% copay
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	80% coinsurance	$75 copay/visit	50% coinsurance	$75 copay/visit Out-of-network urgent care covered only if temporarily traveling out of service area.

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	**OUT-OF-NETWORK** [2]	**IN-NETWORK ONLY** (Out-of-network care is not covered except as noted.)
18. BIOLOGICALLY BASED MENTAL ILLNESS [15] CARE	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. OTHER MENTAL HEALTH CARE [16]				
a) Inpatient care [17]	80% coinsurance	80% coinsurance	50% coinsurance	20% copay
	Maximum 45 inpatient or 90 partial days/year	Maximum 45 inpatient or 90 partial days/year		Maximum 45 inpatient or 90 partial days/year
b) Outpatient care	80% coinsurance	$50 copay	50% coinsurance	$50 copay
	Plan/carrier pays maximum 20 visits per year.	Plan/carrier pays maximum 20 visits per year.		Plan/carrier pays maximum 20 visits per year.
20. ALCOHOL AND SUBSTANCE ABUSE	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18]	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18] (In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)		Diagnosis, medical treatment & referral services. 50% copay.[19]
21. OUTPATIENT PHYSICAL, OCCUPATIONAL & SPEECH THERAPY [20]	80% coinsurance	80% coinsurance	50% coinsurance	$30 copay
	(Limited to 20 visits per therapy per year) [20a]	**(Limited to 20 visits per therapy per year combined in and out-network)** [20a]		**(Limited to 20 visits per therapy per year)** [20a]

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
22. DURABLE MEDICAL EQUIPMENT [21]	80% coinsurance	80% coinsurance	50% coinsurance	20% copay
23. OXYGEN	80% coinsurance	80% coinsurance	50% coinsurance	20% copay
24. ORGAN TRANSPLANTS [22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	80% coinsurance	80% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.
25. HOME HEALTH CARE [22a]	80% coinsurance	80% coinsurance	50% coinsurance	20% copay
26. HOSPICE CARE [22a, 22b]	80% coinsurance per diem	80% coinsurance per diem	50% coinsurance per diem	20% copay
27. SKILLED NURSING FACILITY CARE [23]	80% coinsurance	80% coinsurance	50% coinsurance	20% copay/day
	(Not to exceed 100 days/year)	(Not to exceed 100 days/year)		(Not to exceed 100 days/year)
28. DENTAL CARE	For all plans, not covered except for dental care needed as a result of an accident. [6a, 25a]			
29. VISION CARE	Excluded [6a]	Excluded [6a]	Excluded [6a]	Excluded [6a]
30. CHIROPRACTIC CARE	No [See 31(a)]	No [See 31(a)]	No [See 31(a)]	No [See 31(a)]

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK [2]	IN-NETWORK ONLY (Out-of-network care is not covered except as noted.)
31. SIGNIFICANT ADDITIONAL SERVICES				
a) Spinal manipulation	80% coinsurance	80% coinsurance	50% coinsurance	$30 copay
b) Hearing Aids [23a]	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service	Benefit level determined by place of service
c) Treatment of Autism Spectrum Disorders [23b]	Benefit level determined by type of service provided [23c]	Benefit level determined by type of service provided [23c]	Benefit level determined by type of service provided [23c]	Benefit level determined by type of service provided [23c]

PART C: LIMITATIONS AND EXCLUSIONS

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [24, 24a, 25]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 – 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS **Can an individual's specific, pre-existing condition be entirely excluded from the policy?**	No	No	No	No

	STANDARD INDEMNITY PLAN	STANDARD PPO PLAN		STANDARD HMO PLAN
		IN-NETWORK	OUT-OF-NETWORK	
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[25a] and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids and fitting[25b]; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws [26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

1 Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the carrier may require the insured/member to use in order to get any coverage at all under the plan, or that the carrier may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

2 Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply only if the carrier has network providers for the covered benefit and insured/member goes out of the network. Otherwise, in-network-levels apply.

3 "Out-of-pocket annual maximum" refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

4 However, notwithstanding the copay amounts listed in this standard HMO plan, under no circumstances, with the exception of the prescription drug benefit, shall the copay amount paid by the insured/member exceed 50% of charges for any single service.

5 Medical office visits include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically based mental illnesses.

6 Effective January 1, 2010, coverage includes all preventive services as set forth in § 10-16-104(18), C.R.S. in accordance with "A" and "B" recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided pursuant to Colorado Insurance Bulletin B-4.24. For the standard HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.

6a The covered preventive services, including immunizations and vaccinations, for adults and children are listed in Attachment 1 of this regulation. For those services denoted with Attachment 1's footnote 5:

In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers (for plans with out-of-network benefits): These services can be subject to the plan's out-of-network cost sharing requirements

6b Coverage shall be provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

7 Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

8 The hospital copay applies to mother and well baby together; there are not separate copays.

9 Includes expendable medical supplies for the treatment of diabetes and medically necessary medical foods for inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids pursuant to § 10-16-104(1)(c)(III), C.R.S. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not-applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type).

9a Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

10 Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

10a Copay includes all physician, facility services and supplies delivered during the visit.

11 Includes low dose mammography screening not otherwise covered under the list of preventive care services, as set forth in Colorado law, § 10-16-104(18)(b)(III)(C), C.R.S. Diagnostic services do not include therapeutic treatment.

12 "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

13 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the carrier for non-emergency after hours care, then urgent care coinsurance and copays apply.

14 Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

15 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as medical office visits; however, the copay amount paid by the insured/member shall not exceed 50% of the charge for any single office visit.

16 Pursuant to § 10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to § 10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of § 10-16-105(2), C.R.S., relating to such an exclusion.

17 The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

18 Carriers shall also offer alcoholism coverage pursuant to § 10-16-104(9), C.R.S., as may be amended.

19 Federally-qualified HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101(a)(5).

20 Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age.

20a The services covered and the benefits provided for children under 6 years of age shall be pursuant to the requirements of § 10-16-104, C.R.S., subsections (1.3) and (1.7). Annual maximum for early intervention services is published in Colorado Insurance Bulletin B-4.31. For children under the age of 19, the services provided for the treatment of autism spectrum disorders pursuant to § 10-16-104(1.4), C.R.S., shall exceed the benefit limits if such therapy is medically necessary.

21 Coverage is for the lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered but repair and replacement needed due to misuse/abuse by the insured/member is not covered.

22 Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure and shall include animal-to-human and artificial and mechanical devices as medically appropriate.

22a Covered services are defined in Colorado Insurance Regulation 4-2-8.

22b Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

23 Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

23a Hearing aids for dependent children under the age of 18 are covered pursuant to § 10-16-104(19), C.R.S. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review as provided in §§ 10-16-112, 10-16-113, and 10-16-113.5, C.R.S.

23b Effective July 1, 2010, all medically necessary, appropriate, effective or efficient treatments and/or services for the treatment of autism spectrum disorders as set forth in § 10-16-104(1.4), C.R.S., are covered for children under nineteen years of age. The treatments listed in § 10-16-104(1.4)(a)(XII), C.R.S. are not considered to be experimental or investigational and are considered to be appropriate, effective, or efficient for the treatment of autism.

23c The benefits provided are subject to the dollar limits, deductibles, copays, or coinsurance limits for the type and place of service for the treatment being provided unless otherwise noted. However, the benefits provided pursuant to § 10-16-104(1.4), C.R.S., are in addition to any benefits provided pursuant to subsections (1.3) and (1.7) of § 10-16-104, C.R.S. The following annual maximums are effective for applied behavior analysis services:

- From birth up to, but not including age nine: $34,000.
- Age nine up to, but not including age nineteen: $12,000.

24 Waiver of pre-existing condition exclusions: State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage the insured/member recently may have had.

24a Pre-existing condition exclusions shall not be applied to individuals under the age of 19.

25 The carrier shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

25a Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

25b Only hearing aids for dependent children under the age of 18 are covered pursuant to § 10-16-104(19), C.R.S.

26 Except that if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

Attachment 1

Covered Preventive Services [1]	
All Persons	Chicken pox vaccination for all persons who have not had chicken pox.
	Colorectal screening for all high risk individuals, regardless of age.[1a]
	Immunizations in accordance with the Immunization Schedules of the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention: for children age 0 to 6 years, for children age 7 to 18 years, a "catch-up" schedule for children and for adults. [5]
	Syphilis screening for all adults at increased risk. [5]
Females	Full cost of cervical cancer vaccine. [1b]
	Screening for chlamydial infection: all sexually active women aged 24 and younger and for older females who are at an increased risk. [5]
	Screening for chlamydial infection: all pregnant women aged 24 and younger and for older pregnant females who are at an increased risk. [5]
	Cervical cancer screening for all sexually-active females with a cervix. [5]
	Screening for iron deficiency anemia in asymptomatic pregnant females. [5]
	Screening for asymptomatic bacteriuria with urine culture for pregnant females at 12 to 16 weeks gestation or at first prenatal visit, if later. [5]
	Screening for hepatitis B virus (HBV) for pregnant females at first prenatal visit.[5]
	Rh(D) blood typing and antibody testing for all pregnant females during first prenatal visit and repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative females at 24-28 weeks' gestation. [5]
	Syphilis screening for all pregnant females. [5]
	Pregnant females: Augmented, pregnancy-tailored tobacco counseling. [5]
All Children (Age 0-18 years)	Immunizations, including the influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. [1c, 4] Immunization deficient children are not bound by "recommended ages".
	Ages 12 to 18 years: screening for major depressive disorder. [5]
	Under age 5: Screening to detect amblyopia, strabismus, and visual acuity defects. [5]
	Oral fluoride supplementation for preschool children older than 6 months of age whose primary water source is deficient in fluoride. [5]
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
	Newborns: Screening for hearing loss. [5]
	Newborns: Screening for sickle cell disease. [5]
	Newborns: Screening for phenylketonuiria (PKU). [5]
	Newborns: Prophylactic ocular topical medication against gonococcal ophthalmia neonatorum. [5]

("Age 0-12 months" continued)	Newborns: Screening for congenital hypothyroidism (CH). [5]
	6 well-child visits. [2]
	Ages 6 to 12 months: Routine iron supplementation for asymptomatic children who are at increased risk for iron deficiency anemia. [5]
Age 13-35 months	3 well-child visits.
Age 3-6	4 well-child visits.
	Age 6: Obesity screening and comprehensive, intensive behavioral interventions. [5]
Age 7-12	4 well-child visits.
	Obesity screening and comprehensive, intensive behavioral interventions. [5]
Age 13-18	1 age appropriate health maintenance visit [3] every year.
	1 Td
	Females: screening pap smears not to exceed 1 per year. [4]
	1 hepatitis B vaccination if not given previously. [4]
	Obesity screening and comprehensive, intensive behavioral interventions. [5]
	Sexually Transmitted Infection (STI) prevention counseling for all sexually active adolescents. [5]
	HIV screening for all adolescents at increased risk and all pregnant females. [5]
	Females: Screening for gonorrhea infection for all sexually active females, including pregnant females, at increased risk. [5]
Age 18 and older	Tobacco use screening and tobacco cessation interventions by any provider furnishing primary care services to the patient in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [3a, 5]
	Alcohol misuse screening and behavioral counseling interventions by any provider furnishing primary care services to the patient in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Obesity screening and intensive counseling and behavioral interventions. [5]
	Females: HIV screening for all pregnant females. [5]
	Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk. [5]
	Interventions to promote and support breastfeeding during pregnancy and after birth. [5]
	Blood pressure screening. [5]
	Depression screening. [5]
	Type 2 diabetes screening in asymptomatic adults with sustained with blood pressure (either treated or untreated) greater than 135/80 mm Hg. [5]

("Age 18 and older" continued"	Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care providers or by referrals to other specialists, such as dieticians or nutritionists. [5]
	HIV screening for all adults at increased risk and all pregnant females. [5]
	Females: Screening for gonorrhea infection for all sexually active females, including pregnant females, at increased risk. [5]
	Females: Referral for genetic counseling and evaluation for BRCA testing for females whose family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* genes. [5]
	Females: Breast cancer chemoprevention counseling.[5]
	Females: Folic acid supplements for all females planning or capable of pregnancy. [5]
Age 19-39	1 Td every ten years.
	1 age appropriate health maintenance visit every three years.
	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. [1c, 4]
	Females: screening pap smears not to exceed 1 per year. [4]
	Males ages 20-34: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Males ages 35-39: Screening for lipid disorders in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Females ages 20-39: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
Age 40-64	1 Td every ten years.
	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. [1c, 4]
	Adults ages 50-64: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	1 age appropriate health maintenance visit every 24 months.
	Females ages 40-64: 1 screening mammogram, with or without clinical breast exam, every 1 to 2 years (annually, if high risk). [4, 5]
	Females: screening pap smears not to exceed 1 per year. [4]
	Males: Screening for lipid disorders in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Females: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Females ages 55-64: Aspirin therapy. [5]
	Females ages 60-64: Routine osteoporosis screening for females at increased risk for osteoporotic fractures. [5]

("Age 40-64" continued)	Males: Prostate screening as specified in state law. (Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)
	Males ages 45-64: Aspirin therapy. [5]
Age 65 and older	Influenza and pneumococcal vaccinations pursuant to the schedule established by the ACIP. [1c, 4]
	Females: screening pap smears not to exceed 1 per year. [4]
	1 Td every ten years.
	1 age appropriate health maintenance visit every year.
	Males: Screening for lipid disorders in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Females: Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Females: 1 screening mammogram, with or without clinical breast exam, every 1 to 2 years (annually, if high risk). [4, 5]
	Females ages 65-79: Aspirin therapy. [5]
	Females: Routine osteoporosis screening. [5]
	Adults ages 65-75: Colorectal screening in accordance with the "A" or "B" recommendations of the U.S. Preventive Services Task Force. [4, 5]
	Males: Prostate screening as specified in state law. (Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)
	Males ages 65 to 75: One-time screening for abdominal aortic aneurysm (AAA) by ultrasonography for males who have ever smoked. [5]
	Males ages 65-79: Aspirin therapy. [5]

1 Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) compliant plans and, effective January 1, 2010, coverage includes all preventive services as set forth in § 10-16-104(18), C.R.S. in accordance with "A" and "B" recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services.

1a Colorectal screening shall be provided to all individuals who are at a high risk for colorectal cancer including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

1b Age limitations as recommended by the U.S. Department of Health and Human Services' Advisory Committee on Immunization Practices.

1c "ACIP" means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the federal Department of Health and Human Services.

2 "Well-child visit" means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education

counseling. The schedule of these visits, through age 12, is based on the recommendations of the American Academy of Pediatrics.

3 "Age appropriate health maintenance visit" means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

3a Appropriate copays apply to the provider services and cessation interventions, including drug interventions; however, deductibles and coinsurance do not apply.

4 Appropriate copays apply to the provider services; however, deductibles and coinsurance do not apply.

5 In-network providers: These services are not subject to any cost-sharing requirements (copay, deductible, or coinsurance). If the service or item is not billed separately from an office visit and the primary purpose of the office visit is the delivery of such item or service, then no office visit copay or other cost-sharing requirement can be imposed. If the service or item is not billed separately from the office visit and the primary purpose of the office visit is not the delivery of the service or item, then the office visit copay or cost-sharing requirement can be imposed on the office visit charge. If the service or item is billed separately from an office visit, then the office visit copay or other applicable cost-sharing requirement can be imposed with respect to the office visit charge.

Out-of-network providers: These services can be subject to the plan's out-of-network cost sharing requirements.